A.D. 8.14, Suicide Prevention
Prepared for signature 8/13/99 – effective 9/15/99

1. **Policy. The Department shall actively identify and monitor inmates who may be at risk of self-destructive behavior and shall respond to suicidal inmates. Each facility shall establish procedures for suicide prevention and intervention.**

2. **Authority and Reference.**

   A. **Connecticut General Statutes, Section 18-81.**
   B. **American Correctional Association, Standards for Adult Correctional Institutions, Third Edition, January 1990, Standards 3-4343, 3-4344, 3-4350, 3-4351, 3-4361 and 3-4364.**
   C. **American Correctional Association, Standards for Adult Local Detention Facilities, Third Edition, March 1991, Standards 3-ALDF-4E-11, 3-ALDF-4E-12, 3-ALDF-4E-19, 3-ALDF-4E-20, 3-ALDF-4E-24, 3-ALDF-4E-32 and 3-ALDF-4E-34.**
   D. **American Correctional Association, Standards for the Administration of Correctional Agencies, Second Edition, April 1993, Standard 2-CO-4E-01.**
   E. **National Commission on Correctional Health Care, Standards for Health Services in Prisons, 1997, Standard P-53.**
   F. **National Commission on Correctional Health Care, Standards for Health Services in Jails, 1996, Standard J-51.**
   G. **Administrative Directives 1.4, Cooperation with Community and Governmental Organizations; 1.5, Public Information and News Media Relations; 1.10, Investigations; 2.18, Critical Incident Stress Response Program; 6.4, Transportation and Community Supervision of Inmates; 6.5, Use of Force; 6.6, Reporting of Incidents; 7.2, Armories; 8.2, Inmate Death; and 8.5, Mental Health Services.**

3. **Definitions. For the purposes stated herein, the following definitions apply:**

   A. **Crisis Intervention. The therapeutic response to an inmate in urgent need of mental health care.**
   B. **Infirmary Unit. An area designated for Medical and/or Mental Health care with 24-hour nursing care.**
   C. **Mental Health Emergency. A situation or circumstance requiring an immediate response to an inmate in psychiatric crisis when the lack of an intervention may jeopardize the safety or well being of the inmate, staff, other inmates or the environment.**
   D. **Mental Health Observation. The placement of inmate on one of the following statuses:**

      1. **15-minute Watch. For those not actively suicidal, but have expressed thoughts of suicidal ideation and/or have a prior history of suicidal behavior. Such inmates are to be physically observed by a staff member at staggered intervals not to exceed 15 minutes. This involves observing living, breathing flesh and entering the cell to do so if necessary.**
      2. **One-on-One Continuous Observation. For those actively suicidal either by threatening or engaging in the act of suicide. Such inmates shall be physically observed on a**

continuous and uninterrupted basis. The staff member shall maintain a clear unobstructed view of the inmate at all times.

E. Video Monitored Room. An infirmary room equipped with a video monitoring system that permits observation, recording and audio surveillance of an inmate. A TV monitoring system shall only be utilized as a supplement, and not as a substitute for either a 15-minute watch or one on one continuous observation.

4. Training.

A. Pre-Service Orientation Training. Newly hired staff with direct inmate contact shall complete eight (8) hours of suicide prevention training prior to being assigned to a facility. Staff shall be trained to recognize signs indicative of a potential suicide, the referral process, suicide intervention techniques, administration of first aid and cardiopulmonary resuscitation (CPR) and the provisions of this Directive.

B. Facility Orientation Training. Staff with direct inmate contact shall receive training that includes the general provisions of the Suicide Prevention Unit Directive, Post Order Procedures, suicide intervention techniques, how to respond to a suicide in progress, emergency responses, notification, communication, coordination and use of emergency equipment.

C. In-Service Training. Staff with direct inmate contact shall complete two (2) hours of suicide prevention and emergency procedures training annually. Staff shall have access to professional development workshops, staff development programs and other training which meets their level of professional responsibility.

D. Roll Call Notices. Each facility shall update staff as needed via roll call notices during those times of the year at which suicides are more frequent, or at other such times as directed by the Unit Administrator in consultation with the Director of Health Services.

5. Screening and Identification.

A. Custody staff shall solicit any information regarding an inmate's potential for self-destructive or suicidal behavior upon any transfer from another authority's custody.

B. Custody staff shall immediately communicate any information which suggests risk of suicide to medical intake staff. The communication shall be in writing utilizing the Request for Mental Health Services, HR501, Attachment A and the Mental Health Initial Assessment Form, HR508, Attachment E.

C. Inmates shall be screened by Medical staff upon admission to the facility, prior to placement in general population, for history or other indications which suggest risk of suicide.

D. Medical staff shall conduct a comprehensive health screening for each newly admitted inmate utilizing the Inmate Health Screening Form, CN 9302, or an abbreviated health screening for each inmate admitted from an inter-facility transfer utilizing Transfer Summary, HR005, Attachment B.

E. The admission of an inmate with a mental health needs sub-code of "S," a history or any other indication of suicide potential shall

result in an immediate referral to mental health staff and may initiate the procedures set forth in Section 9 below.

F. Mental Health Staff shall initially complete the Suicide Risk Assessment Form, CN 81401, Attachment C and the Mental Health Initial Assessment Form, HR508, Attachment E, for each referred inmate.

G. Following the completion of the mental health assessment, appropriate custody and health services staff shall be notified of the inmate's risk of self-destructive behavior and the recommendations for a management plan.

H. Health Services staff shall notify a classification supervisor of an inmate appropriate for a mental health needs sub-code of "S" in accordance with Administrative Directive 9.2, Inmate Classification.

6. Referral. An inmate who may be at risk of self destructive behavior or who have threatened or attempted suicide shall be referred in accordance with the provisions of this Directive.

7. Monitoring. Each facility shall have a comprehensive system of monitoring and documented supervision of inmates that have potential for self-destructive behavior. An inmate with a mental health needs sub-code of "S" shall receive a mental health assessment (1) upon admission; (2) placement on or removal from restrictive housing and (3) quarterly.

8. Assessment of Suicide Risk. Suicide potential shall be assessed by mental health staff who shall designate the inmate's level of suicide risk and the need for transfer in accordance with Section 9 of this Directive. The criteria listed below may indicate greater potential for suicide are intended to assist staff in formulating a plan of prevention and treatment.

A. Suicidal Plan. There is a well-organized and detailed plan developed by the inmate. The potential increases when the means of the suicide identified in the plan is readily available to the inmate and/or the inmate gives away personal property.

B. Prior Suicidal Behavior. The inmate has one (1) or more prior suicide attempts, repeated threats of suicide or has a history of depression.

C. Stress. The inmate is subject to stress from increased pressures including but not limited to the following:

1. difficulties in coping with legal problems;
2. the loss of a loved one through death or divorce;
3. the loss of valued employment (e.g., position in correctional industries);
4. anniversary of incarceration date or offense;
5. serious illnesses or diagnosis of terminal illness;
6. threats or perceived threats from other inmates;
7. physical/sexual victimization;
8. placement on cell restriction or any movement to or in a Restrictive Housing Unit;
9. punishment or change in legal status (e.g., misconduct, additional sentence, parole denial or rejection of motion for sentence review or modification);
10. previously held position of respect in the community;

11. discontinuation of vocational or educational programming;
12. crime of high notoriety;
13. recent transfer from another facility; or
14. somatic complaints of a vague nature which do not respond to treatment.

D. Prior Suicidal Behavior of a Significant Other. A parent, spouse or other close relative or friend has attempted or committed suicide.

E. Symptoms. The inmate exhibits symptoms such as:

1. auditory and visual hallucinations, particularly command hallucinations;
2. delusions;
3. increase or decrease in the hours of sleep;
4. any change from the inmate's normal food consumption, which may be accompanied by a decrease or increase in weight;
5. social withdrawal;
6. apathy;
7. despondency;
8. severe feelings of helplessness and hopelessness;
9. general attitude of physical and emotional exhaustion;
10. agitation through such symptoms as tension, guilt, shame, poor impulse control or feelings of rage, anger, hostility or revenge;
11. sudden elevated mood ("everything's OK attitude"); and
12. deterioration of personal hygiene and/or personal appearance.

F. Personal Resources. The inmate does not have an adequate support system. The inmate may remove all visitors from the visiting list, may have no family or friends, or feel rejected by family and friends. Potentiality is greater if the inmate perceives a significant other as defensive, rejecting, punishing or unwilling to accept that the inmate needs help.

G. Acute vs. Chronic Aspects. There is a sudden onset of specific symptoms, a recurrent outbreak of similar symptoms, or a recent increase in long-standing maladapted traits.

H. Medical Status. There is a chronic, debilitating illness, especially when it involves an alteration of physical appearance or level of functioning.

An inmate considering suicide does not demonstrate all of these signals. Generally, the more characteristics the inmate has, the greater the potential for self-destructive behavior. All suicidal attempts, including perceived gestures and threats, shall be taken seriously.

9. Emergency Mental Health Intervention.

A. Emergency Plans. Each facility shall have a comprehensive written plan which directs staff response to a range of mental health emergencies, ensures the appropriate level of staff training and communication and which provides for emergency medical response and equipment. The procedures should include: methods for handling a suicide in progress, administration of

first aid and CPR and the duties of first and subsequent responders, supervisors, and Health Services staff.

B. Emergency Referral.

1. A staff member shall immediately advise a shift supervisor and Health Services staff of an inmate who exhibits abnormal or self-destructive behavior or threatens suicide. A Health Services staff member may, based on an assessment, place an inmate on one-on-one continuous observation or 15-minute watch.
2. In emergency situations when no Health Services staff are present, the Shift Supervisor shall place the inmate on the appropriate mental health observation and shall notify the facility duty officer and the on-call psychiatrist for further instruction.
3. If, in the opinion of the Shift Supervisor, the inmate's behavior would reasonably be believed to result in serious danger to the inmate, staff, other inmates, or the environment, the inmate shall be placed in full stationary restraints in accordance with Section 16 of this Directive. The Shift Supervisor shall notify the facility duty officer and contact the on call Complex Health Services Administrator to facilitate transfer of the inmate to a designated Mental Health Level 5 facility for assessment.

C. Documentation. The Suicide Risk Assessment form, a written assessment and recommendations shall be documented by Health Services staff and maintained in the Mental Health section of the inmate's health record. When an inmate is placed on 15-minute watch or one-on-one continuous observation assigned staff shall document such observation on the Close Observation Checklist form, HR505, Attachment D.

D. Transfers. An inmate determined to be an immediate risk of self destructive behavior by licensed Health Services staff shall be transferred to a designated Mental Health Level 5 infirmary for assessment, evaluation, and treatment, or to a community hospital emergency room, the Department of Mental Health and Addiction Services or the Department of Children and Families. Such transfers shall be considered health emergency transfers and shall be made by the Complex Health Services Administrator or designated Health Services staff in coordination with the Director of Classification and Population Management and the Unit Administrator. Transfers shall conform to the standards set forth in Administrative Directive 6.4, Transportation and Community Supervision of Inmates.

10. Housing and Management of Inmates on Mental Health Observation. An inmate on any mental health observation status shall be managed in accordance with the standards set forth in this section. An inmate assessed as suicidal shall be promptly transferred to an infirmary. In those facilities without an infirmary, the Shift Supervisor shall determine the most appropriate housing in a cell or room that is safe, protrusion-free, and adequate for a potentially suicidal inmate, until the inmate is transferred. Such a cell or room shall have a locked door, should allow for ease of observation, quick access and limited and secure furnishings in order to promote inmate safety.

A. **One-on-One Continuous Observation (in the Absence of Health Services Staff).**

1. The room or cell in which the inmate is to be maintained shall be searched.
2. The inmate shall be subject to a strip and visual body cavity search.
3. The inmate shall be issued an authorized safety gown and blanket.
4. Assigned staff shall document observations in accordance with a 15-minute watch, on the Close Observation Checklist, HR505, Attachment D.
5. The inmate shall be allowed to attend to bodily functions as needed.
6. The inmate shall be offered fluids at least every two (2) hours.
7. The inmate shall be provided bite-sized foods and liquids at meal times.
8. Food and fluid intake/output and refusal shall be documented.

B. **One-on-One Continuous Observation (in an Infirmary).** In addition to the standards set forth in Section 10(A), the following measures shall be taken in an infirmary:

1. Placement in an infirmary shall require assessment by a Registered Nurse or physician. In the absence of an on-site physician, the Registered Nurse shall obtain a placement order within one (1) hour.
2. Qualified Health Services staff shall conduct an assessment of an inmate on one on one continuous observation at a minimum of every two (2) hours.
3. The physician may discontinue one on one observation subsequent to a direct evaluation. In the absence of a physician, a Registered Nurse may discontinue one on one continuous observation with a telephone order from a physician.
4. The physician's order shall not exceed three (3) hours. Prior to the termination of the physician's order, the inmate shall be evaluated by a physician or Health Services staff.
5. Continuation of one-on-one continuous observation status shall require a subsequent assessment and physician's order which shall be documented in the inmate's health record.
6. Any additional items or activities require specific authorization by a physician.

C. **15-Minute Watch.**

1. When an inmate is on 15-minute watch, assigned staff shall check the inmate for living, breathing flesh at every interval, and shall document the observation on the Close Observation Checklist, HR505, Attachment D.
2. When the inmate is out of cell, the staff member shall maintain continuous observation and remain within close proximity, allowing for rapid intervention.

3. Qualified Health Services staff shall conduct an assessment of the inmate on 15-minute watch at minimum every two (2) hours.
4. The physician may discontinue the 15-minute watch subsequent to a direct evaluation. In the absence of a physician, a Registered Nurse may discontinue the 15-minute watch with a telephone order from a physician.

11. Mental Health Commitment. If the inmate remains a high suicidal risk, the facility mental health staff shall initiate a mental health commitment to a licensed inpatient facility in accordance with Administrative Directive 8.5, Mental Health Services.

12. Notification. Each facility shall establish notification procedures of potential, attempted and completed suicides in accordance with Administrative Directives 1.4, Cooperation with Community and Governmental Organizations; 1.5, Public Information and News Media Relations; 6.6, Reporting of Incidents; and 8.2, Inmate Death.

13. Reporting. Each Health Services Unit shall establish procedures for maintaining a log of the name, number and date an inmate was placed on 15-minute watch, one-on-one continuous observation and/or threatened, attempted or completed suicide for the purpose of suicide prevention review. Each facility's Health Services Unit shall forward a monthly statistical report of the number of inmates placed on 15-minute watch, one-on-one continuous observation, suicide assessments, suicide threats, suicide attempts and successful suicides to the Director of Health Services and the Unit Administrator. An annual report encompassing the relevant facts on the Department's suicide prevention program shall be prepared by the Director of Health Services and submitted to the Deputy Commissioner of Programs.

14. Review. In the event of an inmate suicide, a comprehensive clinical and administrative review shall occur in accordance with Administrative Directives 6.6, Reporting of Incidents and 8.2, Inmate Death. Such analysis shall include, at a minimum, the conclusion of administrative investigations in accordance with Administrative Directive 1.10, Investigations, and recommendations for system improvement to prevent future occurrences.

15. Critical Incident Debriefing. Each facility shall establish procedures for offering critical incident debriefing to potentially effected staff and inmates in accordance with Administrative Directive 2.18, Critical Incident Stress Response Program.

16. Restraints. Restraints shall be used only in situations that are directly proportionate to the presence of imminent physical danger to the inmate, others or the environment.

A. No On-Site Health Services Staff. Placement of an inmate in full stationary restraints shall be in accordance with Administrative Directive 6.5, Use of Force. Soft restraints shall be used. The placement shall require an order from the on-call psychiatrist within one (1) hour.

B. On-Site Health Services Staff.

1. Criteria. An order to restrain shall be subsequent to an evaluation by a physician. If a physician is not on-site, an assessment shall be made by a Registered Nurse with a telephone order obtained within an hour from a physician and so documented. The physician may discontinue restraints subsequent to a direct evaluation. In the absence of a physician, a Registered Nurse may discontinue restraints with a telephone order from a physician.
2. Equipment. Restraint equipment shall be approved by the Director of Health Services and shall be maintained in accordance with Administrative Directive 7.2, Armories.
3. Procedure. This procedure shall be implemented in collaboration with supervising custody staff. The inmate shall be placed on a bed mattress which is positioned on top of a bed frame. The inmate shall be positioned face up. Arms and legs shall be restrained such that discomfort to the inmate is minimized. The following checks shall occur at the indicated intervals:

a.	Circulation:	every 15-minutes
b.	Respiration:	every 15-minutes
c.	Pulse:	every 30 minutes
b.	Blood Pressure:	every 60 minutes
e.	Temperature:	every 120 minutes

These checks shall be executed and documented by Health Services Staff in the inmate health record. At least every two (2) hours the restraints must be totally removed or serially removed and each limb of the inmate moved to full range of motion and assessed for trauma, blood circulation, and/or diminished nerve sensation. The inmate shall be allowed to attend to bodily functions as needed. Restrained inmates shall receive normally scheduled meals. Meals shall be bite-sized and served on paper plates, unless a physician has ordered alternate dietary arrangements. If feasible, the inmate may have one (1) arm released to use for feeding. Fluids shall be offered every two (2) hours. Food and fluid intake/output and refusal shall be documented. Immediate removal of restraints shall be initiated where a decompensating physical condition of a restrained inmate contraindicates restraints. In such circumstances, the physician shall be notified immediately.

C. Management. The inmate shall be managed in accordance with Section (B) of this Directive (standards for management of inmates on one-on-one continuous observation in infirmaries). At no time shall an inmate be placed in full stationary restraints without a covering.

D. Reports. Health Services staff for each facility shall forward a monthly statistical report, of all use of restraints for mental health, to the Director of Health Services.

17. Interdisciplinary Briefings. Interdisciplinary briefings among custody, medical and mental health staff shall be coordinated on a regular basis by the Director of Health Services or designee.

18. **Exceptions**. **Any exception to the procedures contained in this Administrative Directive shall require the prior written approval of the Commissioner.**

CN 81401
6/11/99

ATTACHMENT C

SUICIDAL RISK ASSESSMENT FORM

Inmate Name_____ **Number**_____

To be completed by the Mental Health Unit staff on all inmates who are assessed to have a suicidal risk based on their recent behavior or verbal threats.

THE INMATE HAS (IS):	YES	NO
1. Made a verbal threat with or without a specific plan		
2. History of attempts		
3. History of treatment for depression		
4. History of successful suicide in family		
5. Recently suffered a loss		
6. Had an emotional crisis within past 3 months		
7. Made negative comments about future		
8. Made self-depreciating remarks		
9. Recently been depressed		
10. Increased hours of isolation		
11. Terminated a relationship, refused to see friends, stopped attending groups and work assignments		
12. Giving away possessions, paying off debts		
13. Verbalized feelings of abandonment		
14. Experienced an anniversary of a sad event		
15. Feels people have a right to suicide if they wish		
16. Lack of an adequate support system		
17. Experienced changes in: A) weight; B) sleep patterns; C) eating patterns; D) mood; E) other/specify:		
18. Self-mutilation behavior		
19. Does inmate currently perceive himself to be in danger (pay attention to the inmate who is in a panic about real or imaginable dangers)		
20. Experienced change in correction status (issues regarding housing, parole, changed in risk level, movement within and between facilities, visitation, DRs, etc.)		
21. Are there mitigating circumstances, explain		

NOTE: Write a specific note related to those questions which have YES answers.

_____
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_____
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_____
_____
_____
_____

Interviewed by_____ **Date**_____
Signature and Title **Time**_____